TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 – 0 4 1

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 3, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY ~~unknown~~ 2004 $ 24.5 million
b. FFY ~~unknown~~ 2005 $ 24.5 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D pages 15-15.4

P & I
Attachment 4.19D pages
5, 10, 12, and 15-15.4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D pages ~~15-15.4~~
New page ~~15.4~~

P & I attachment 4.19D pages
5, 10, ~~12~~, and 15-15.4

10. SUBJECT OF AMENDMENT:
Medi-Cal Long Term Care Rates

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governors office does not wish to review State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Stan Rosenstein

14. TITLE:
Deputy Director

15. DATE SUBMITTED:

16. RETURN TO:
Department of Health Services
Attn: State Plan Coordinator
1501 Capitol Avenue,
Suite 71.4143
Sacramento, CA 95814

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 17 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 3 – 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Bum for Smith

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:
P & I changes mail per State submittal of plan pages to correct
Pagination 4/28/04
Box 7 - P & I changes to reflect FFP per State

FORM HCFA-179 (07-92) *Instructions on Back*

(c) NF level B/subacute...no bedsize category
(d) DP/NF level B/subacute...no bedsize category
(e) NF level B/pediatric subacute...no bedsize category
(f) DP/NF level B/pediatric subacute...no bedsize category
(g) NF level A... no bedsize category
(h) DP/NF level A ... no bedsize category
(i) ICF/DD...1-59, 60+ and 60+ with a distinct part
(j) ICF/DD-H...4-6 and 7-15
(k) ICF/DD-N...4-6 and 7-15
(l) Swing-beds...no bedsize category
(m) Transitional inpatient care...no bedsize category

4. Geographical location:

(a) Freestanding NF levels A and B and DP/NF level A:
(1) Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, and Sonoma counties.
(2) Los Angeles county.
(3) All other counties.
(b) DP/NF level B, freestanding NF level B/subacute and pediatric subacute, DP/NF level B/subacute and pediatric subacute, transitional inpatient care, ICF/DDs, ICF/DD-Hs, and ICF/DD-Ns,...statewide.
(c) Rural swing-beds...statewide.

J. Special Treatment Program (STP)

For eligible Medi-Cal patients 65 years or older who receive services in an Institution for Mental Disease the STP patch rate will apply. This is a flat add-on rate determined to be the additional cost for facilities to perform these services. STP does not constitute a separate level of care.

II. COST REPORTING

A. All long term-care facilities participating in the Medi-Cal Program shall maintain, according to generally accepted accounting principles, the uniform accounting systems adopted by the State and shall submit cost reports in the manner approved by the State.

Institutions Code, and Article 1.5 (Provider Audit Appeals) of Title 22, California Code of Regulations. See Appendix 2.

E. When facilities being audited have more than one cost report with an end date in the audit year, the last report will be the one audited, except in those cases where a facility-specific audit adjustment will be applied or actual audited costs are used. In these cases, all cost reports with an end date in the audit year will be audited.

F. All state-operated facilities will be subject to annual audits.

G. Cost reports for nursing facilities that are distinct parts of acute care hospitals may be audited annually.

H. All subacute and pediatric subacute providers will be subject to annual audits.

I. All transitional inpatient care units may be subject to annual audits.

IV. PRIMARY REIMBURSEMENT RATE METHODOLOGY

Reimbursement rates shall be reviewed by the Department at least annually. Prospective rates for each class shall be developed on the basis of cost reports submitted by facilities. The following method shall be used to determine rates of reimbursement for a class of facilities when cost reports are available:

A. Audit Adjustment.

1. An audit adjustment shall be determined for each of the following classes:

   (a) NF level B field audited facilities with 1-59 beds.
   (b) NF level A field audited facilities with no bedsize category
   (c) NF level B field audited facilities with 60+ beds.
   (d) ICF/DD field audited facilities with 1-59 beds.
   (e) ICF/DD field audited facilities with 60+ beds.
   (f) ICF/DD-H field audited facilities with combined bedsizes.
   (g) ICF/DD-N field audited facilities with combined bedsizes.

2. Except for DP/NFs and subacute providers, where the audit sample exceeds

overpayments in the case of class audit adjustments.

6. The results of federal audits, when reported to the state, may be applied in determining audit adjustments.

B. Adjustment for facilities which provide a different type of service from the remainder of the class.

Additional amounts, where appropriate, shall be added to the payment rates of individual facilities in a class to reimburse the costs of meeting requirements of state or federal laws or regulations including the costs of special programs.

C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal laws and regulations which would impact upon such costs. These adjustments will be reflected as an "add-on" to the rates for these costs and, where appropriate, an "add on" may be used to reflect other extraordinary costs experienced by intermediate care facilities for the developmentally disabled (including habilitative and nursing facilities for the developmentally disabled). Add ons for extraordinary costs shall not be considered for other categories of long term care providers. To the extent not prohibited by federal law or regulations, "add-ons" to the rate may continue until such time as those costs are included in cost reports used to set rates under this state plan.

For example, state or federal mandates may include such costs as changes to the minimum wage or increases in nurse staffing requirements. An example of other extraordinary costs might include unexpected increases in workers compensation costs or other costs which would impact facilities ability to continue to provide patient care.

A brief description of all add-ons included in the current year's rate study will be provided to HCFA by December 31st of the rate year, as a part of Supplement 1.

D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.

9. ICF/DDs (except state operated facilities), ICF/DD-H and ICF/DD-N facilities will be reimbursed at the 65th percentile, instead of the median, in recognition of the fact that they serve a disproportionate share of low income patients with special needs.

10. Subacute services which are provided in both distinct parts of acute care hospitals and freestanding NFs shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate, broken down by ventilator and non-ventilator and DP or freestanding NF.

11. The subacute rate includes additional ancillary costs. Where available, the facility's projected cost is based on the audited ancillary cost data. In the event that audited ancillary costs are not available, the facility's projected cost is based on the median of the projected subacute ancillary costs of the facilities in the study that have audited ancillary costs.

12. For purposes of setting the DP/NF or subacute prospective class median rate, the Department shall use the facility's interim projected reimbursement rate when their audit report is not issued as of July 1st.

13. (a) For the rate year 2002-03, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2002-03 rate year, will have its subacute prospective reimbursement rate for 2002-03 set at its 2001-02 rate. The facility's 2002-03 subacute prospective reimbursement rate will be no more than the 2002-03 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

(b) For the rate year 2003-04, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2003-04 rate year, will have its subacute prospective reimbursement rate for 2003-04 set at its 2002-03 rate. The facility's 2003-04 subacute prospective reimbursement rate will be no more than the 2003-04 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

14. Any facility that has been a NF-A 100+ bedsize facility will no longer have its reimbursement rate adjusted at the same percentage increase as other NF-level As. Its reimbursement rate will be based on the applicable methodology described in this Section IV paragraph F.

15. (a) Nursing facilities and other specified facilities as identified in Section 14110.65 of the Welfare and Institutions Code, will be eligible to request and receive a supplemental rate adjustment when the facility meets specific requirements.

(b) In order to qualify for the rate adjustment, the facility must have a verifiable written collective bargaining agreement or other legally binding, written commitment to increase non-managerial, non-administrative, and non-contract salaries, wages and/or benefits that complies with Section 14110.65 of the Welfare and Institutions Code and regulations adopted pursuant thereto.

(c) Except as provided in subparagraph (d) below, the rate adjustment will be equal to the Medi-Cal portion (based on the proportion of Medi-Cal paid days) of the total amount of any increase in salaries, wages and benefits provided in the enforceable written agreement referenced in subparagraph (b). This amount will be reduced by an increase, if any, provided to that facility during that rate year in the standardized rate methodology for labor related costs (see Section I.E of this state plan) attributable to the employees covered by the commitment. A rate adjustment made to a particular facility pursuant to this subparagraph 15 will only be paid for the period of the non-expired, enforceable, written agreement. The Department will terminate the rate adjustment for a specific facility if it finds the binding written commitment has expired and does not otherwise remain enforceable.

(d) A rate adjustment under this subparagraph 15 will be no more than the greater of 8 percent of that portion of the facility's per diem labor costs, prior to the particular rate year (August 1st through July 31st), attributable to employees covered by the written commitment, or 8 percent of the per diem labor costs of the peer group to which the facility belongs, multiplied by the percentage of the facility's per diem labor costs attributable to employees covered by the written commitment.

(e) The payment of the rate adjustment will be subject to certification of the availability of funds by the State Department of Finance by May 15 of each year and subject to appropriation of such funds in the State's Budget Act.

(f) This subparagraph 15 will become effective as of the first day of the month following the date that this provision is approved by the Centers for Medicare and Medicaid Services.

16. (a) Hospice care rates apply to four basic levels of care: Routine Home Care, Continuous Home Care, Inpatient Respite Care, and General Inpatient Care. Each year after the end of the Federal fiscal year (September 30), the Centers for Medicare & Medicaid Services provides the Department of Health Services with the new Medicare rates and the wage indices for the various groupings of California counties. Each Medicare rate for the services referenced above consists of a wage and non-wage component. The wage component of each Medicare rate is multiplied by the wage index for each county grouping and the result is added to the non-wage component to arrive at the reimbursement rate for hospice care services rendered within the particular county grouping. These rates are effective from October 1 through September 30 of each year.

(b) Effective January 3, 2004, in addition to the reimbursement for the services referenced in (a) above, payment to facilities for room and board services shall be made at 95 percent of the Medi-Cal facility rate where the patient resides, if the facility is classified as one of the following:

- Nursing Facility Level B
- Nursing Facility Level A
- Intermediate Care Facility – Developmentally Disabled
- Intermediate Care Facility – Developmentally Disabled, Habilitative
- Intermediate Care Facility – Developmentally Disabled, Nursing

G. Notwithstanding paragraphs A through E of this Section, prospective rates for newly licensed DP/NF-Bs shall be based on the facility's historical costs of providing NF-B services regardless of ownership or licensure.

For DP/NF-Bs with historical costs as a licensed freestanding NF-B, the Department shall establish a prospective DP/NF-B rate based on the freestanding NF-B cost report. If the newly licensed DP/NF-B has reported costs as both a freestanding NF-B and DP/NF-B, the Department shall establish the facility's historical-costs basis by combining the freestanding NF-B and DP/NF-B total patient days and costs. Newly licensed DP/NF-Bs shall receive prospective rates based on available freestanding NF-B cost reports until the Department uses the consolidated hospital DP/NF-B cost report and/or audit in the appropriate rate study.

Newly licensed DP/NF-Bs without historical costs of providing NF-B services shall receive an interim reimbursement rate. This interim rate shall be based on the DP/NF-B's projection of their total patient days and costs, as approved by the Department. When actual DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-Bs final prospective rate. Final DP/NF-B rates may be less than the interim rate, in which case the Department shall recover any overpayment.

H. Subacute providers that do not have historical costs shall receive an interim reimbursement rate. This interim rate shall be based on the subacute facility's projection of their total patient days and costs, as approved by the Department. When actual subacute audit report data becomes available, interim rates will be retroactively adjusted to the subacute facility's final prospective rate. Final rates may be less than the interim rate, in which case the Department shall recover any overpayment. Only subacute providers participating in the program as of June 1st will be included in the rate study.

I. Notwithstanding Paragraphs A. through G. of this Section, San Mateo County Hospital shall receive an interim reimbursement rate for the skilled nursing facility located at 1100 Trousdale Drive in Burlingame, California. The interim rate will be effective on August 1, 2003 and will be equal to the hospital DP/NF rates of its existing DP/NF skilled nursing facility located at 222 West 39th Avenue in San Mateo, California. The interim rate will apply through July 31, 2006.

J. In accordance with Section 14105.06 of the Welfare and Institutions Code and notwithstanding paragraphs A through F of this Section, all Medi-Cal long-term care facility rates that went into effect August 1, 2003, will remain unchanged through July 31, 2005, and be in effect for the period August 1, 2003, through July 31, 2005. This provision applies to all long-term care facility types (except those operated by the State), including the following:

1. Freestanding nursing facilities licensed as any of the following:

(a) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code.

(b) An intermediate care facility pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(c) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code.

2. A skilled nursing facility that is a distinct part of a general acute care hospital as defined in Section 72041 of Title 22 of the California Code of Regulations.
3. A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.
4. An adult day health care center.

V. DETERMINATION OF RATES FOR NEW OR REVISED PROGRAMS

A. When the State adopts a new service or significantly revises an existing service, the rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.

B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study. After five years from the end of the fiscal year in which a facility begins participating in a program for Medi-Cal reimbursement, the reimbursement rate methodology will either revert to the provisions described in Section I through IV of Attachment 4.19-D or be subject to new provisions as described in a State Plan amendment.